Division of Public Health
Purchase of Medical Care Services

DME, Supplies and Formula Billing Guide

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Contact Us

DHHS
Purchase of Medical Care Services
1904 Mail Service Center
Raleigh, NC, 27699-1904

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919-855-3701
Claims Inquiries
919-855-3702

POMCS Unit Supervisor
919-855-3650

POMCS Claims Supervisor
919-855-3653

POMCS Authorization Supervisor
919-855-3652

POMCS Provider Relations Supervisor
919-855-3651

POMCS Website:
http://www.ncdhhs.gov/control/pomcs/pomcs.htm

This guide has been prepared to assist providers in billing the following fee for service payment programs through Purchase of Medical Care Services.

Adult Cystic Fibrosis Program
Assistive Technology Program
Children's Special Health Services (CSHS)
Kidney Program
Migrant Health Program
Sickle Cell Program

AUTHORIZATION OF SERVICE

Before an Authorization Request can be approved, the following must be met:

1. The patient must qualify financially and have an approved Financial Eligibility Application (DHHS-3014) on file for the following programs:
   - Adult Cystic Fibrosis
   - Kidney Program
   - Sickle Cell Program
2. For the CSHS Program you must verify that the patient is Medicaid eligible on the date of service.
3. Children under the Assistive Technology Program must be enrolled in the Infant Toddler Program.

Services must first be authorized before you can bill one of the

programs above. A physician or physical therapist will submit the Authorization Request (DHHS - 3056), and the request must be received by the program within one year after the date of service.

For CSHS, you may receive Medicaid's Certificate of Medical Necessity \ Prior Approval form for pediatric mobility systems. Requests to CSHS for pediatric mobility systems must also include:

1. A letter of medical necessity signed by a physician or PT\OT;
2. An itemized list of components with verification of catalog price and appropriate Medicaid code for each item (submitted on Medicaid's Certificate of Medical Necessity \ Prior Approval Form)

REPLY TO AUTHORIZATION REQUEST

Once a request is processed a reply is sent to the provider, client, and interviewer as well as other parties listed on the form who require knowledge of the status. The reply gives details pertaining to the status of the request by letting you know if it has been approved, denied or placed in pending status for additional information.

On the system generated reply to Authorization Request letter, the authorization number is shown at the right of the patient's case number. The letter will also indicate the patient's Medicaid number and insurance information, if known.

If additional information is requested by POMCS, it must be received within one year after the date of service or within 30 days after the date it is requested, whichever is later.

Migrant Program

For the Migrant program there is a separate process which requires a Migrant Fee-For-Service Eligibility form (DHHS – 3753). The form must be completed and sent by an interviewer from one of the designated Migrant Health Entry Points. Durable medical equipment under the Migrant Health Program must have prior approval from the Program Manager, Melissa Miles (919-733-2040).

CLAIM SUBMISSION

Providers of durable medical equipment, medical supplies, and formula must bill on the HCFA/CMS 1500 claim form. Providers of developmental books, computers, and other items not classified as durable medical equipment may bill on their invoices.

Claims must be received within one year after the date of service or within 45 days after the date of authorization, whichever is later. Please be sure to write the program name in block 19 and case

number and authorization number in block 23 of the HCFA/CMS 1500 claim form. If the HCFA/CMS 1500 is not required, please write these numbers prominently on the invoice. Providers must utilize the appropriate North Carolina Medicaid Provider number or NPI in accordance with CMS deadlines when submitting claims. **Providers billing CSHS DME must bill the approved codes per the Reply to Authorization or accompanying attachments**. Enter the HCPCS procedure code for each item or component in the procedure code column of the HCFA/CMS 1500. Units must be billed as specified for the code. Refer to the following link for a list of Medicaid codes: http://www.dhhs.state.nc.us/dma/fee/dme_rates.pdf. If there is no valid Medicaid HCPCS code for an item, provide the Medicare code, if available. If you use a Medicare code, please include a description of the service. If there is no procedure code, write "no code" in the procedure code column and provide a detailed description to the right of the procedure code column.

DME **labor** can not be billed without prior approval. Labor must be submitted based on North Carolina Medicaid guidelines and will be priced accordingly.

Providers billing **formula** must enter the total number of calorie units dispensed in the "days/units" column of the claim form. *To determine the number of calorie units, multiply the number of calories per can by the number of cans dispensed and divide that number by 100.* **Identify formula by name and HCPCS code**. For a current listing of HCPCS codes for formula refer to the following link:http://www2.palmettogba.com/classifications/enteral%20nutrition.pdf

INSURANCE / MEDICAID

Claims for CSHS/Assistive Technology services, such as, durable medical equipment and supplies may be billed to POMCS with appropriate prior authorization. For CSHS this applies even though the patient may be Medicaid eligible. Claims should be submitted directly to Medicaid for items on Medicaid's fee schedules such as pediatric mobility systems, diabetic supplies, enteral formula, and any supplies used to administer enteral formula. For all other programs, claims for services covered by Medicaid must always be billed directly to Medicaid.

Providers must bill other payors and wait at least six months after the date of service to receive payment or denial of payment before billing POMCS. A copy of the EOB must be attached to the claim.

POMCS cannot authorize services to be provided by vendors who will not bill insurance. If you receive an authorization for a patient who has insurance, and you do not bill insurance, please notify us so that we can find another provider.

REIMBURSEMENT

Payment will be at the Medicaid rate of reimbursement in effect at the time your claim is received to include labor billing. Sales tax is

Refunds of DHHS Payments

Refunds
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not reimbursable. Items may be priced manually based on Medicare rates or the provider's usual and customary rate, whichever is lower.

POMCS will process claim within 45 days of receipt which will generate either payment or a reply. The Reply to Claim (DHHS 3741) will deny or specify the status of the unpaid claim.

Corrections to claims and requests for payment adjustments must be received by POMCS within 1 year after date of service or within 45 days after the claim is paid or returned for additional information, whichever is later.

You may not bill the patient for any item for which you have accepted partial or total payment from us. You may bill the patient for any item for which you do not accept our payment. If you receive another third party payment after we have paid, you must refund the lesser of the two amounts to POMCS.

State of North Carolina
Michael F. Easley, Governor
North Carolina Department of Health and Human Services
Carmen Hooker Odom, Secretary